BlueCross BlueShield Nebraska

BlueFlex

Group Underwriting Guidelines

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I. Eligibility

Definition

A small group (Group) shall mean an employer who has applied to Blue Cross and Blue Shield of Nebraska (BCBSNE), including any person, political subdivision, firm, corporation, limited liability company, partnership or association that is actively engaged in business that, on business days during the previous calendar year, employed an average of at least five eligible employees and no more than 50 eligible employees. The Group must be headquartered in the state of Nebraska. In certain situations, determined solely at BCBSNE's discretion, it might be possible to obtain a cede for a Group headquartered outside the state of Nebraska.

The Group may be formed by an employer as a business concern, provided the business operates a minimum of six months per year on a regular basis and maintains a legitimate employer/employee relationship. The Group cannot be formed for the sole purpose of obtaining health insurance.

A Group is not considered new when the same management is involved and there is merely a transfer of a majority of members from one Group opportunity to another, or when the only change is in the ownership or the name of the business and the content of the Group has not changed materially in its characteristics or substantially in eligible employees.

A parent company must be a majority owner – 51% or greater – in any subsidiary in order to combine the subsidiary and parent into one group, provided the percentage of enrollment is met for the total group. The separate businesses must be identified on the proposal request and the application for Group contract.

Non-profit organizations cannot have common ownership and will not be able to combine with another organization for insurance purposes, unless they are a part of the same non-profit organization.

Example:

Company Alpha	
Owner A	50%
Owner B	40%
Owner C	10%

Company Delta	
Owner A	50%
Owner B	25%
Owner D	25%

Company Omega	
Owner A	40%
Owner B	10%
Owner E	50%

In this example, Companies Alpha and Delta can be consolidated because Owner A and Owner B together own the majority interest (51% or more) in both companies. Company Omega cannot be consolidated with Alpha and Delta because there is not 51% common ownership with Companies Alpha and Delta.

General Eligibility Requirements

All regular full-time and permanent part-time employees, other than seasonal or temporary employees, who are actively performing the duties of their principal occupation, for the required minimum (17½ hours per week) are eligible for coverage through the employer Group.

Individuals not eligible for coverage in a group are those not actively employed by the Group, such as owners or part owners, independent contractors, members of the board of directors, retirees (regardless of age), trustees and shareholders and those who are employed for short periods of time such as Saturdays, holidays or summer vacations.

Group contracts contain the following provision: "If two eligible persons in the same group are married to each other, each individual and/or their eligible dependents shall not enroll in more than one membership unit under this contract. Similarly, if two eligible persons have a parent/child relationship and both are employed by the same employer groups, the parent and child may elect to enroll one of two ways:

a. As two employees, or

b. The parent enrolls as an employee with dependent coverage

Enforcement of this provision is up to the Group since they control the initial enrollment of their employees.

COBRA participants are not considered eligible employees and are not counted toward participation and enrollment. COBRA participants must not make up more than 10% of the total Group. COBRA is available to groups with 20-50 employees.

Any exceptions to these general eligibility requirements require the approval of the Group Underwriting Department.

Eligibility Requirements for the Group

Small Group: See Definition Section in Section I.

Group Size Requirement: A minimum of at least five eligible employees enrolled and no more than 50 eligible employees will be required to apply for coverage.

II. Rating Factors

Existing or new business Groups may not be appropriate for a BlueFlex quote. This is not a guaranteed issue product. All groups are subject to underwriting and may be declined a quote based on ongoing medical diagnoses/conditions.

Other Rating Factors

Groups are subject to other rating factors based on the following:

- Demographic composition of the Group
- Location within the state of Nebraska
- Number of employees residing outside Nebraska
- Participation
- Contribution
- Network

Contribution: The amount an employer contributes toward the costs of the health insurance plan.

Contribution Requirement: The minimum employer contribution is 50% of the average single membership rate.

Participation: Participation will be determined by comparing the number of employees enrolling to the number of Total Eligible Employees (excluding employees with other creditable coverage).

Total Eligible Employees: Number of employees who meet the qualifications for health insurance coverage as defined in the General Eligibility Section.

Valid Waivers - Other Qualifying/Creditable Coverage: Employees who have health insurance coverage elsewhere such as through a spouse, parent, Medicare, Medicaid or an individual policy.

Participation Requirement: A minimum participation requirement of at least five eligible employees must be enrolled. At least one of the five enrolled employees must reside in the State of Nebraska. A Group must maintain at least five enrolled employees with one residing in Nebraska to continue coverage. The minimum net employer participation requirement is:

- 100% participation for groups with five eligible employees
- 100% less one life participation for groups with six to nine eligible employees
- 75% participation for groups with 10-50 eligible employees

If the employer is paying the entire contribution for the employee, 100% participation will be required.

The minimum gross employer participation requirement is 50% of all eligible employees.

Rating Disclosure

Individual Group rates are initially established based on the case characteristics of the Group, including number of enrollees, age/sex composite of the members, location, industry, effective date and the benefit/network option selected. The rates initially provided to a Group are preferred rates. Groups will be evaluated to determine eligibility for preferred rates and may subsequently be adjusted for participation and health status. In addition, BCBSNE reserves the right to recalculate and change the rates previously proposed based on inadequate or inaccurate disclosures during the RFP or application process that would affect BCBSNE's underwriting or rating decisions.

If additional applications are received after the initial medical review has been completed, underwriting will need to review and update the rates based on demographic changes and the revised medical review. If the rates are not impacted by more than a 5% increase, in most cases there will be no adjustment to the rates.

Subsequent rating actions are based primarily on the overall experience of the pool of Groups, and secondarily on the experience of each Group.

Any changes made to the census within 60 days of issue that date back to the original effective date may result in a rate adjustment.

BCBSNE reserves the right to change rates on any due date after the first year or whenever the contract terms change.

Multiple Options

Groups are allowed to select up to three BlueFlex benefit options as well as all three network options, if applicable. If the Group elects to offer all three network options, employees who reside outside ZIP codes starting with 680, 681 and 683-685, and outside of the Buffalo, Hall, Phelps, Kearney and Adams counties, will only be eligible to enroll in the NEtwork BLUE network option. Employees who reside in ZIP codes starting with 680, 681, 683-685 may enroll in the Premier Select BlueChoice, Blueprint Health or NEtwork BLUE network options. Employees who reside in Buffalo, Hall, Phelps, Kearney or Adams counties may enroll in either the Blueprint Health or NEtwork BLUE network option. Any employees residing outside the state of Nebraska are not eligible to choose the Premier Select BlueChoice or Blueprint Health network option, unless prior approval is received from Underwriting.

NEtwork BLUE is the only network option available to Groups headquartered outside ZIP codes starting with 680, 681 and 683-685, and outside the Buffalo, Hall, Phelps, Kearney and Adams counties.

Blueprint Health, Premier Select BlueChoice and NEtwork BLUE network options are available to groups who are headquartered inside ZIP codes starting with 680, 681 or 683-685. NEtwork BLUE and Blueprint Health networks are available to groups headquartered inside Buffalo, Hall, Phelps, Kearney or Adams counties.

Groups with five to nine enrolled employees can select up to two medical options and any combination of our three networks. Groups with 10-50 enrolled employees can select up to three medical options and any combination of our three networks.

Creditable Coverage

Coverage of the individual under any of the following: (a) a Group health plan, as defined by the Health Insurance Portability and Accountability Act (HIPAA); (b) health insurance coverage consisting of medical care offered by a health insurance issuer in the Group or individual market; (c) Part A or Part B of Medicare; (d) Medicaid, other than coverage consisting solely of benefits for pediatric immunizations; (e) medical and dental care of the uniformed services; (f) a medical care program of the Indian Health Service or a tribal organization; (g) a state health benefits risk pool; (h) the Federal Employees Health Benefits Program; (i) a public health plan, which means a plan providing health coverage that is established by a state, the U.S. government, or a foreign country, or a political subdivision thereof; (j) a health plan of the Peace Corps; or (k) a State Children's Health insurance Program (SCHIP).

Creditable coverage does not include coverage described in HIPAA as "expected benefits," e.g., coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit-only insurance; coverage for on-site medical clinics; limited-scope dental or vision coverage or long-term care coverage; non-coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

III. New Business / Renewal Package

New Business Package

All components of the new business package must be received no later than the first of the month in which coverage is effective. New Groups will be effective on the first of the month. The components of the new business package are as follows:

- ACH Authorization Form
- The Master Group Application (MGA) should be fully completed and signed by an authorized representative of the company and the appointed agent/broker
- Final quote, Business Associate Agreement (BAA), stop loss contract (96-093 Rev. 11-2018), Administrative Services Agreement (ASA) and the medical contract should be attached upon signature of the MGA
- Individual enrollment forms
- Verification of employment (UI-11)

The new business package is subject to approval by BCBSNE, and no commitments for acceptance should be made. When the new business package is approved, the appointed agent/broker will be notified in writing.

If the effective date, enrollment or other assumptions made at the time of proposal change when the proposal is sold, BCBSNE's Group Underwriting department reserves the right to retract the quote, or change rates, benefits and/or effective date of coverage.

Renewal Package

As a condition of renewal, Group employers are required to complete the Employer's Report of Employee Data for Group Health Insurance (survey). This is used to verify compliance with BCBSNE Underwriting Guidelines. If the Group does not provide completed survey back to BCBSNE at least 90 days prior to the effective date, the Group will receive a delayed renewal package. Any subsequent information submitted after renewal rates are released will not be eligible for renewal revision.

The Group's failure to provide necessary documentation, or noncompliance with the underwriting guidelines as a result of this review, will be treated as a failure to meet stated guidelines and the Group will not be renewed. The Group and agent/broker will be notified of the termination of the contract.

Groups must submit acceptance of their renewal in writing to BCBSNE prior to the renewal date. The contract shall be non-renewed or discontinued for Groups if:

1. BCBSNE has not received payment.
2. There is no longer any subscriber who lives, resides or works in a service area where BCBSNE is licensed.
3. This contract form or particular type of contract is no longer offered in the 5-50 Group market applicable to this Contract.
4. The Group applicant has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

5. The headquarters of the Group are no longer located in the State of Nebraska.
6. The contract is issued to an association, and membership in the association ceases. Coverage for that association subgroup and its Covered Persons may be terminated.
7. The Group fails to meet the Underwriting Guidelines.
8. The Group does not respond to survey requests by Underwriting and the account management team prior to the effective date; the group will be sent a termination letter via email 30 days prior to termination.

Rate Guarantee

Group rates are guaranteed for 12 months, and any change of anniversary date must be approved by the Group Underwriting department. However, if a Group changes to an anniversary date of Jan. 1 before the next renewal, due to election of a high deductible health plan, the Group will be subject to Underwriting review and the anniversary date will be changed accordingly.

If the number of covered employees increases or decreases 5% or more, or the terms of the Contract are changed, BCBSNE reserves the right to change the rates.

IV. Signature Blue Dental Coverage

Dental coverage consists of the following four categories:

- Coverage A, Preventive and Diagnostic Dentistry
- Coverage B, Maintenance and Simple Restorative Dentistry and Oral Surgery
- Coverage C, Complex Restorative Dentistry, Periodontic and Endodontic Dentistry
- Coverage D, Orthodontic Dentistry

Dental coverage class is not required to match medical coverage class. Groups with prior group dental coverage may receive a rate discount. Orthodontic dentistry is not available to groups with less than 10 eligible employees.

Persons who do not enroll within 31 days of eligibility have only Coverage A benefits for the first 12 months of coverage. Exceptions are allowed for special enrollment due to marriage, newborns, adoptions, court orders, increases in employer contributions, death, divorce and involuntary terminations.

Dental Participation: Calculation used to determine if Group is eligible for coverage. Participation will be determined by comparing the number of employees enrolling to the number of Total Eligible Employees (excluding employees with other dental coverage).

If the employer is paying the entire premium for the employee, 100% participation will be required.

For Groups paying less than 100% of the employee premium, after excluding persons covered under creditable coverage, a minimum net participation of 60% of total eligible employees is required. In addition, a Group must also have a minimum gross participation of at least 50% of all eligible employees enrolled, regardless of the number of or types of waivers.

The minimum employer contribution is 60% of the single membership rate for all covered employees.

V. Special Enrollment and Late Enrollment

Special Enrollment

Special enrollment periods can occur if a person loses eligibility for other coverage, employer contributions are terminated, or if a person becomes a dependent through marriage, birth, adoption and placement for adoption. The person must apply within 31 days of the qualifying event. Special enrollment is also available if a person loses eligibility for Medicaid or a State Child Health Insurance Program (SCHIP) or if a person becomes eligible for premium assistance under Medicaid or SCHIP. In those cases, the person must apply within 60 days of the qualifying event.

The special enrollment period for marriage, birth, adoption and placement for adoption applies also to the employee and spouse even if not previously covered through the Group.

Late Enrollment

Late enrollment periods can occur if persons (employees and/or dependents) do not apply for coverage within 31 days of eligibility and do not meet the definition of a special enrollee. A late enrollee will only be allowed to apply for coverage during the month prior to the annual renewal date. Enrollment forms must be signed by the last day of open enrollment and must be received by BCBSNE within 31 days.

Temporary Lay-offs, Leaves of Absence, Disability

The Group's documented personnel rules regarding sick leave and leaves of absence will determine continued eligibility. As long as the employer considers the employee to still be eligible for fringe benefits according to documented personnel rules, eligibility will be maintained. Once the employment status is terminated, the employee is eligible for any coverage dictated by federal (COBRA or Family Leave Act) or state law.

In the absence of documented sick leave or leave of absence policy, continued coverage on an active employee basis for a maximum of six months will be allowed.

Reinstatement Policy

Groups terminated for nonpayment may be reinstated once during a 12-month period, but not more often, and only with the approval of the Group Underwriting Department. The receipt of two notices of nonsufficient funds within a 12-month period constitutes nonpayment, and the Group will be terminated for nonpayment. Reinstatement requests should be accompanied by a money order or cashier’s check for the amount of the arrears within 24 hours. A Group which requests reinstatement after voluntary termination will be subject to full medical underwriting.